Complete Summary

GUIDELINE TITLE

Evidence-based protocol. Elderly suicide: secondary prevention.

BIBLIOGRAPHIC SOURCE(S)

Holkup P. Evidence-based protocol. Elderly suicide: secondary prevention. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2002 Jun. 56 p. [120 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Suicide

GUIDELINE CATEGORY

Prevention
Risk Assessment

CLINICAL SPECIALTY

Geriatrics
Nursing

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses

GUIDELINE OBJECTIVE(S)

To provide an evidence-based practice protocol that will assist nurses or other health care providers in recognizing at-risk suicidal behavior in the elderly and providing appropriate and effective crisis intervention

TARGET POPULATION

Elders who come in contact with nurses or other health care providers in a variety of settings including hospitals, rehabilitation centers, outpatient clinics, mental health clinics, home health care, and long-term care facilities

INTERVENTIONS AND PRACTICES CONSIDERED

Strategies for secondary prevention of suicide

1. Identification and assessment
    - Assessment of verbal, behavioral, situational, or syndromatic warning signs that may signal suicidal ideology
    - Assessment of internal or external protective factors
    - Assessment of risk factors associated with elderly suicide
    - Use of assessment tools [Psychosocial Assessment Form; additional assessment tools, including risk factor assessment instruments (SAD PERSONS Scale), depression assessment instruments (Beck Depression Inventory, Geriatric Depression Scale, Hopelessness Scale), alcoholism assessment instruments (CAGE Test for alcoholism, Michigan Alcoholism Screening Test-Geriatrics), instruments to assess suicidal ideation (Scale for Suicide Ideation, Suicidal Behaviors Questionnaire, Reason for Living Inventory)]
    - A history and physical examination with laboratory tests as indicated to detect depression and alcoholism
2. Crisis intervention
    - Establishment of rapport
    - Assessment of level of suicidal risk
    - Consultation with mental health professional or another colleague
    - Hospitalization if indicated
    - No-suicide contract
    - Implementation of ongoing program
        - Treatment of presenting symptoms
        - Referral to therapy, support groups, or community programs, as indicated

MAJOR OUTCOMES CONSIDERED

Suicide rates and risk among the elderly

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

MEDLINE: Keywords = suicide + age + risk factors; suicide + meta-analysis

CINAHL: Keywords = suicide (limited ages); suicide assessment; suicide prevention; suicide risk; age + suicide; suicide (classification, diagnosis, epidemiology, ethical issues, etiology, evaluation, prevention & control, psychosocial factors, symptoms)

HAPI: Keywords = suicide; suicide assessment; suicide prevention

PsychINFO: Keywords = suicide (limited to gerontology); suicide prevention (limited age, empirical studies); suicide + risk populations + psychodiagnostic interview; suicide + meta-analysis; suicide + meta-analysis + elderly

NUMBER OF SOURCE DOCUMENTS

More than 314

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The grading schema used to make recommendations in this evidence-based practice protocol is:

A. Evidence from well-designed meta-analysis.
B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g. assessment, intervention or treatment).
C. Evidence from observational studies (e.g. correlational, descriptive studies) or controlled trials with inconsistent results.
D. Evidence from expert opinion or multiple case reports.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Reviewed by series editor Marita G. Titler, PhD, RN, FAAN and expert reviewers Kathleen Buckwalter, PhD, RN, FAAN, Associate Provost for Health Sciences and Professor, College of Nursing, University of Iowa, Iowa City, Iowa, Howard Butcher, PhD, RN, APRN, BC, Assistant Professor and John A Hartford Building Academic Geriatric Nursing Capacity Post Doctoral Scholar, University of Iowa, Iowa City, Iowa, and Jennifer Bradley, BSN, RN,C, Master Student, University of Iowa, Iowa City, Iowa.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (A-D) are defined at the end of the Major Recommendations.

Refer to the original guideline document for a discussion of individuals/patients at risk for suicide.

Assessment

The following assessment criteria indicate patients who are likely to benefit the most from use of this evidence-based practice protocol. This section includes a) a list of warning signs that may signal suicidal ideology, b) a list of protective factors that could be important to draw upon when intervening with a suicidal patient, and c) a profile of the typical elder who is at risk for attempting suicide.

Warning Signs

Osgood identified four categories of warning signs or clues to suicidal ideation. These are: verbal, behavioral, situational, and syndromatic (Evidence Grade = D).

Verbal clues can be direct or indirect (Evidence Grade = D). Refer to the original guideline for examples of verbal clues.

Behavioral clues also may be direct or indirect.

- The most direct clue is a failed suicide attempt. Because elders make much fewer suicide attempts in relation to completed suicides, the elder who has made an attempt should be considered high risk (Evidence Grade = D).
- Indirect behavioral clues include the following activities (Evidence Grade = D):
    a. Stockpiling medications.
    b. Purchasing a gun.
    c. Making or changing a will.
    d. Putting personal affairs in order.
    e. Giving money or possessions away.
    f. Donating one´s body to science.
    g. Sudden interest or disinterest in religion.
    h. Self-neglect.
    i. Difficulty performing household or social tasks.
    j. Deterioration of relationship behaviors.
    k. A general down-turn in health status. Failure to thrive.
    l. Scheduling an appointment with a physician for vague symptoms. Studies have shown that elders who have completed suicides had seen their physicians in the weeks just prior to the suicidal act.

Situational clues are those events or situations elders experience that may trigger depression that could lead to suicide.

- It is important for the nurse or other health care provider to be aware of situations in the patient´s life that are current psychosocial stressors or recent crises. These include the risk factors (particularly the proximal psychosocial and physical health risk factors) identified above such as a recent move, death of a spouse, child, or friend, or the diagnosis of a terminal illness (Evidence Grade = D).

Syndromatic clues are a constellation of symptoms that are related to suicide.

- It is particularly important for nurses or other health care providers to be sensitive to these clusters of symptoms because elderly frequently do not seek out mental health services; neither do they verbalize complaints of depression. Some groups of symptoms that could provide insight into suicidal ideation include (Evidence Grade = D):
    a. Depression accompanied with anxiety.
    b. Tension, agitation, guilt, and dependency.
    c. Rigidity, impulsiveness, and isolation.
    d. Changes in sleeping and eating habits.
    e. Sudden recovery from a deep depression.

Protective Factors

Protective factors, relative to suicide prevention, are important resources that the nurse or other health care provider can draw upon when working with a suicidal elder. Protective factors can be either internal or external strengths.

Internal resources include those interpersonal and adaptive skills that an elder has utilized throughout his or her life. These might include:

- The potential for understanding, relating, benefiting from experience, benefiting from knowledge, acceptance of help (Evidence Grade = D).
- The capacity for loving, wisdom, sense of humor, social interest (Evidence Grade = D).
- Possession of a sense of purpose or meaning in life (Evidence Grade = C).
- A history of successful transitions, coping independently, acquisition of life skills, the ability to reminisce especially about past successes (Evidence Grade = D).

External resources include those strengths that are available to the elder from the community environment. These might include:

- The presence of a caring and available family and supportive community network (Evidence Grade = D).
- The presence of a caring, available, and knowledgeable nurse or other health care provider and health network (Evidence Grade = D).
- Membership in a religious community, particularly Catholic or Jewish (Evidence Grade = D).
- Commitment to personal values and ideals, people, groups, creative work, and/or social, political, or intellectual causes (Evidence Grade = D).
- Women have a suicide rate much lower than men. It has been suggested that protective factors include the presence of greater flexibility in coping skills based on multiple roles that women fill throughout their lives. Also suicide for elderly women is less socially acceptable than for men (Evidence Grade = C). Finally, there is a negative relationship between the number of children a woman has had in marriage and suicide risk. The more children a woman has, the lower her risk of suicide (Evidence Grade = C).

Profile of the elder at risk for suicide

The following profile provides a condensed summary of the risk factors associated with elderly suicide.

- Gender

  Male (Evidence Grade = C).

- Religion

  Protestant, but seldom attends church. Religious beliefs in general might act as a buffer against suicide, however, being a member of the Catholic or Jewish religion seems to provide a greater protective factor than membership in a Protestant religion (Evidence Grade = D).

- Race

  White (Evidence Grade = C).

- Marital status

  Widowed or divorced (Evidence Grade = C).

- Living environment

  Urban, living alone, isolated, recent move (Evidence Grade = D).

- Employment status

  Retired or unemployed (Evidence Grade = D).

- Physical health

  Poor health, terminal illness, presence of pain, debilitating illness/es, multiple illnesses (Evidence Grade = C).

- Mental health

  Depressed, alcohol abuse or dependence, lonely, hopeless, sense of fatalism, low self-esteem, decreased life satisfaction (Evidence: see section on risk factors in the original document).

- Personal background

  May have a family history of suicide and mental illness such as depression and/or chemical dependence. May have a personal history of previous depression, other mental disorder, or a personal history of chemical abuse or dependency. May have a history of a broken home, harsh parenting, and/or early childhood trauma (Evidence: see section on risk factors in the original guideline document).

- Motivation

  The desire to commit suicide is not often motivated by current interpersonal problems. There does not appear to be a desire to inflict pain on others. Rather the suicide often is intra-psychically motivated and related to a wish to end an intolerable situation (Evidence Grade = C).

- Lethality of method

  Uses the most lethal methods for suicides such as guns, hanging, jumping (Evidence Grade = C).

- Previous suicide attempt

  Is usually successful on the first suicide attempt. However, if there is a failed attempt, the elder should be considered high risk (Evidence Grade = D).

- Methods of reaching out for help

Is not inclined to use crisis intervention centers or hot lines. Also does not speak directly of symptoms of depression or suicide ideation. Rather he or she most often presents with somatic complaints. Many have seen a physician from six months to forty-eight hours prior to completed suicide. However, without special training there is wide variation among the ability of physicians to identify and implement a holistic treatment program for depression (Evidence Grade = C).

Assessment Tools, Instruments and Forms

Several assessment tools are available to assess elderly who are suicidal. An example of a psychosocial assessment form is found in Appendix A.1 of the original guideline document. Additionally, there are several assessment tools that focus on assessing risk factors such as depression, alcoholism, and suicidal ideation. Brief descriptions of the assessment tools and where to find them are found in Appendix A2 of the original guideline document.

Description of the Practice

Secondary prevention of elderly suicide includes the following components: identification, assessment, and crisis intervention. These three components are discussed below. Additionally, focus will be placed on documentation strategies and peer support for the nurse or other health care provider who is faced with management decisions related to the prevention of an elderly suicide. Informational websites in Appendix B of the original guideline document contain information that nurses may find helpful in carrying out the practice.

Blazer (J Geriatr Psych. 1991 24(2),175-190; Evidence Grade = D) discussed the implications of a risk factor approach to suicide prevention. First, knowledge of the risk factors of elderly suicide provides the nurse or other health care provider with an empirical base from which to assess the degree of suicide risk related to the elder´s symptoms. Second, by determining which risk factors are present, a more aggressive approach for their treatment can be implemented. By easing the pain of just one risk factor a suicide may be prevented. Third, the risk factor approach supplies a concrete framework by which the provider can enter into an often times taboo subject, and discuss with the patient and his or her family the presenting symptoms and their implications for the danger of suicide.

Identification of the Suicidal Elder

- It is important for the nurse or other health care provider to know if the agency with which he or she is affiliated has a suicide policy/protocol and to be thoroughly acquainted with its content. If the agency does not have a suicide policy, then the nurse or other health care provider should help the agency establish one (Kohr & Phoenix, 1999) (Evidence Grade = D).
- The nurse or other health care provider must have thorough knowledge of the risk factors, warning signs, and protective factors. These have been described in previous sections of this protocol (Blazer, 1991; Boxwell, 1988; Conwell, 1997; Faiver, Eisengart, & Colonna, 1995; Free Lance Interviews with Expert Physicians et al., 1998; Gallagher-Thompson & Osgood, 1997; Osgood, 1992; Osgood & Thielman, 1990; Raskob, 1998; Valente, 1993; Valente, 1993-94) (Evidence Grade = D).

- Because elders who are feeling depressed, generally do not make use of mental health services but rather present with somatic symptoms, it is important that screening for depression and/or suicide ideation be done at the same time that a health assessment is done (Diekstra & van Egmond, 1989; Finkel & Rosman, 1995; Horton-Deutsch, Clark, & Farran, 1992; Mellick, Buckwalter, & Stolley, 1992; Purcell, Thrush, & Blanchette, 1999; Saarinen, Hintikka, & Lehtonen, 1998) (Evidence Grade = C).
- The following features should be included in an initial assessment of an elder who might be considered at risk for suicide (Osgood, 1982):
    a. The diagnostic interview should include listening for the presenting symptoms, probing for current sources of stress or concern and recent losses, listening for symptoms of depression such as fatigue, weight loss, insomnia, feelings of helplessness and hopelessness, vague somatic complaints of pain or aches (Osgood, 1992) (Evidence Grade = D).
    b. A physical examination with laboratory tests can help to detect depression and alcoholism (Osgood, 1992) (Evidence Grade = D).
    c. Information related to the following should be gathered:
        1. History of family and personal mental health problems such as depression, alcoholism, prior suicide attempts, and suicide or suicide attempts in other family members (Osgood, 1992) (Evidence Grade = D).
        2. Coping abilities and other strengths (Osgood, 1992) (Evidence Grade = D).
        3. Past and current family relationships (Osgood, 1992) (Evidence Grade = D).
        4. Information about current resources, both internal and external (Osgood, 1992) (Evidence Grade = D).
        5. Philosophical approach to suicide—is it an acceptable option? In what situations is it acceptable? (Tallmer, 1995) (Evidence Grade = D).

Assessment of the Suicidal Elder

- Although there are several instruments (referred to in Appendix A.2 in the original guideline document) that can be used to screen for suicidal ideation, depression, and alcoholism, some authors expressed skepticism about relying on them very heavily. First, a structured oral or written questionnaire can seem cold and uncaring at a time and in a situation when rapport is essential. Second, determining the level of suicide risk for an elderly patient almost always is an ambiguous endeavor and reliance on a structured scale or questionnaire, might give the nurse or other health care provider a false sense of certainty regarding the degree of suicide risk. When assessing the level of risk for a suicidal patient, peer supported clinical judgment based on empirically sound information is paramount (Maris, 1992; Range & Knott, 1997; Tallmer, 1995; Valente, 1993-94) (Evidence Grade = D).
- It is necessary to establish a trusting and respectful rapport between the nurse and the patient (Glass & Reed, 1993; McIntyre et al., 1996; Pillai, 1997; Richman, 1994; Richman, 1995; Valente, 1993) (Evidence Grade = D).
- Pillai (Elderly Care. 1997 9(3),18-21; Evidence Grade = D) offered the following guidelines for essential sensitive interviewing skills when meeting

with an elder who is depressed and possibly suicidal. The nurse or other health care provider should:

a. Show empathy with the patient, in words and expression. Listen attentively and, reflect feelings, for example, "It sounds like you are feeling that life is no longer worth living".
b. Make early eye-contact and maintain it at a level with which the patient feels comfortable.
c. Be sensitive to emotional cues and half expression statements.
d. Use plenty of open questions, especially when asking patients to describe their emotions. For example, you could say, "Could you tell me how it is for you to feel so alone right now?"
e. Ask for clarification where needed.
f. Use appropriate questions to bring out key diagnostic criteria. For example, you might ask, "Are you feeling so low right now that you could consider suicide?" and "What might keep you from killing yourself?"
g. Do not bury yourself in your notes.
h. Allow the patient to express distress, and to cry if necessary.
i. Refrain from talking too much yourself (Pillai, 1997).

- If it is suspected that the elder is suicidal, it is important to ask direct questions to determine if the elder wishes to end his or her life and if so, is there a suicide plan? Direct questions such as the following are appropriate to be used to learn this information (Antai-Otong, 1990; Arbore, 1998; Boxwell, 1988; Conwell, 1997; Free Lance Interviews with Expert Physicians et al., 1998; Gallagher-Thompson & Osgood, 1997; Liptzin, 1991; McIntyre et al., 1996; Osgood, 1987; Osgood, 1992; Raskob, 1998; Valente, 1993; Whall, 1987) (Evidence Grade = D).
    a. Are you feeling so down that you see no point in going on?
    b. Have you ever thought about killing yourself?
    c. How often have you had these thoughts?
    d. How would you kill yourself if you decided to do it?
- Evaluating the lethality of the plan is important. This involves determining how specific the plan is, the lethality of the chosen method, and the availability or accessibility of the means to commit suicide (Arbore, 1998; Free Lance Interviews with Expert Physicians et al., 1998; Glass & Reed, 1993; Osgood, 1987; Osgood, 1992; Rice, 1997; Valente, 1993; Valente, 1993-94) (Evidence Grade = D).
- Determine if the suicidal individual has any homicidal thoughts and toward whom (Valente, 1993) (Evidence Grade = D).
- Ask about what has kept the patient from carrying out his or her plan thus far? The answer to this question might illuminate the presence of protective factors that can be used to help the individual think about alternative options (Evidence Grade = D).
- Interview the family members asking about the patient´s mood, level of hope, and suicide clues they might have observed, such as purchasing a gun, stock-piling medications, changing a will (Boxwell, 1988; Rice, 1997; Strasburger & Welpton, 1991; Valente, 1993; Valente, 1993-94) (Evidence Grade = D).

Crisis Intervention

- Rapport continues to be the most important component of the intervention. A helpful therapeutic attitude involves emphasizing the realistic positive while not denying the perception of the overwhelming problem (Richman, 1994) (Evidence Grade = D). Therefore it is appropriate to welcome the conflicted, despairing, destructive, and angry feelings that might be present in the suicidal patient. These can be welcomed because they communicate the need for help (Pillai, 1997; Rice, 1997; Richman, 1994; Richman, 1995) (Evidence Grade = D).
- Once it is determined that the patient is suicidal, the level of risk will establish the direction of the intervention. A major decision to be made is whether the patient needs to be hospitalized (Boxwell, 1988; Osgood, 1987; Osgood & Thielman, 1990; Richman, 1994; Valente, 1993; Valente, 1993-94; Whall, 1987) (Evidence Grade = D).
    a. Because the decision often is ambiguous, the nurse or other health care provider should request a consultation with a mental health professional or another colleague. If the nurse or other health care provider is alone with the patient (for example, in the patient´s home) a call to the mental health center´s crisis line or to the emergency department of the local hospital can provide helpful consultation. It is important to have these numbers available before a crisis occurs. (This process might differ from community to community so in order to be prepared for a crisis, it will be necessary to learn how such services work in your community.) (Boxwell, 1988; Valente, 1993) (Evidence Grade = D).
        1. Explain to the patient why such a call is important.
        2. If the patient will consent, arrange for the consultant to speak with the patient.
    b. Without leaving the patient alone, the nurse or other health care provider should discuss his or her concerns regarding the patient´s situation with the consultant (Boxwell, 1988; Freelance Interviews with Expert Physicians et al., 1998; McIntyre et al., 1996; Rice, 1997; Strasburger & Welpton, 1991) (Evidence Grade = D).
    c. The following guidelines should be taken into consideration when making a decision for hospitalization. It is important to remember that assessing severity of suicidal risk often is ambiguous; therefore attaching a prioritizing or weighting system to the guidelines is unrealistic and could provide a false sense of certainty about the decision to hospitalize or not to hospitalize. If the nurse or other health care provider has any doubt in making a decision to hospitalize a patient, the following guidelines for hospitalization should be discussed with a mental health professional:
        1. Evidence of high levels of unresolved stress in conjunction with symptoms of decompensation (Richman, 1994) (Evidence Grade = D).
        2. Loss of impulse control (Richman, 1994) (Evidence Grade = D).
        3. Lack of a supportive social support network (Richman, 1994) (Evidence Grade = D).
        4. Seriousness of intent. Because elderly express suicide ideation infrequently and are likely to complete suicide if they attempt it, unless there is strong evidence that a suicide attempt is no longer a possibility, the elder should be hospitalized (Osgood & Thielman, 1990) (Evidence Grade = D).

5. Potential for lethality. If the planned method is lethal, such as using a gun or jumping from a high place, the individual should be hospitalized and protected against suicide attempts (Osgood & Thielman, 1990) (Evidence Grade = D).
6. Patient cooperation. If the patient is unable to respond to and cooperate with the concern of the nurse or other health care provider hospitalization may be necessary (Osgood & Thielman, 1990) (Evidence Grade = D).
7. Location of the patient. A patient living alone should not be left alone. If no member of the family or social community is available to stay with the patient, then hospitalization is advised (Osgood & Thielman, 1990) (Evidence Grade = D).

d. If hospitalization is deemed necessary but if the patient has no way of getting there, or if he or she refuses to go to the hospital, it will be necessary to call 911 to dispatch someone from the police or sheriff´s department to escort the patient to the hospital. The patient should never drive himself or herself to the hospital. (Again it is important to learn what services your community has in place for such emergencies.) (Free Lance Interviews with Expert Physicians et al., 1998) (Evidence Grade = D).

- The primary goal of crisis intervention is to maintain the patient´s safety. Therefore it is important to (Conwell, 1997; Glass & Reed, 1993; Valente, 1993-94) (Evidence Grade = D):
    a. Reduce or eliminate imminent danger (Conwell, 1997; Free Lance Interviews with Expert Physicians et al., 1998; Kohr & Phoenix, 1999; Osgood, 1987) (Evidence Grade = D).
    b. Never leave a patient alone who is actively suicidal (Free Lance Interviews with Expert Physicians et al., 1998; Kohr & Phoenix, 1999; McIntyre et al., 1996; Whall, 1987) (Evidence Grade = D).
    c. Involve family members or significant others who care, so they can stay with the patient until the crisis has passed and the patient is receiving and benefiting from mental health care (Boxwell, 1988; Free Lance Interviews with Expert Physicians et al., 1998; Valente, 1993; Valente, 1993-94) (Evidence Grade = D).
    d. These measures, as well as the decision to hospitalize, should be conducted with sensitivity, keeping the patient informed of the actions that are necessary to take, and the reasons for the actions. If possible enlist the patient´s cooperation (McIntyre et al., 1996) (Evidence Grade = D).
- Sometimes a no-suicide contract can be initiated. However, if the patient demonstrates a high risk of suicide or is angry and manipulative, it is not wise to rely on a no-suicide contract as a preventive measure. A no-suicide contract is neither a guarantee that the suicide will not happen nor is it a substitute for clinical judgment. If the use of a no suicide contract is deemed appropriate, a mental health professional should be the person to implement it. When it is appropriate to use them, no-suicide written contracts should include the following components (Raskob, 1998; Valente, 1993) (Evidence Grade = D).
    a. An agreement from the patient to not harm himself or herself.
    b. An agreement that the patient will contact the mental health care provider if the patient´s suicidal impulses become unmanageable.
    c. An agreement from the mental health care provider to be available to the patient for a specified period of time, usually until the patient

returns for a follow up visit or another part of the intervention has taken place (e.g. when the patient has met with a psychotherapist for evaluation and therapy).
    d. Contact phone numbers for the mental health care provider.
    e. Both the patient and the mental health care provider sign the contract. A copy is given to the patient and the original is kept in the agency records.
- Implement an ongoing program of help. This can involve such measures as (Blazer, 1991; Freelance Interviews with Expert Physicians et al., 1998; Gambil & Scott, 1997; Glass & Reed, 1993; Liptzin, 1991; McIntyre et al., 1996; Osgood, 1987; Osgood & Thielman, 1990; Pillai, 1997; Richman, 1994; Valente, 1993) (Evidence Grade = D):
    a. Treatment of the presenting symptoms.
    b. Referral for individual or group therapy.
    c. Referral to support groups.
    d. Referral to a community program for elderly at risk of suicide, if one exists (Morrow-Howell, Becker, & Judy, 1998) (Evidence Grade = B).
    e. If the patient is not hospitalized and until the treatment program is in effect, the nurse or other health care provider must continue to monitor the patient to ascertain his or her safety (Valente, 1993-94) (Evidence Grade = D).

Documentation

- It is important for the nurse or other health care provider to keep careful, although not over-inclusive, records of the encounter with the elder who is suicidal (Kohr & Phoenix, 1999; Rice, 1997; Strasburger & Welpton, 1991) (Evidence Grade = D).
    a. Follow your agency´s policy for documenting situations involving suicidal risk.
    b. The Psychosocial Assessment Form in Appendix A.1of the original guideline can be used as an assessment tool as well as a means of documentation. In addition records should include statements made by the patient; your decision-making process; potential ramifications of non-treatment; what has been shared with the patient and the family; and the consultation process.
    c. Do not include your speculations about the patient´s unconscious motivations or what your counter-transference feelings might be. (Counter-transference feelings are those feelings evoked in the nurse or health care provider by the patient´s behavior. Examples of such feelings might include fear, anger, or disbelief.)

Support for the Nurse or Other Health Care Provider

When encountering a patient who is at risk of suicide it is important to be aware of the stress and personal toll this stress takes on the nurse or other health care provider. Therefore, it is important to (Corey, Corey, & Callanan, 1993; Strasburger & Welpton, 1991) (Evidence Grade = D):

- Know your personal and professional limits and practice within them.
- Become familiar with the legal standards that are pertinent to your particular discipline regarding suicide and duty to report, confidentiality, and liability.

- Consult with your peers so you are not the only person responsible for the decisions of the suicidal patient.
- Periodically consult with peers for stress debriefing as needed.
- If, despite all your efforts a patient commits suicide, it is important to have a peer review of the actions that were implemented. It may also be helpful to request the services of a professional mental health counselor to provide a critical incident stress debriefing session for all health care personnel who were involved with the patient.

Definitions:

Evidence Grading

A. Evidence from well-designed meta-analysis.
B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment).
C. Evidence from observational studies (e.g., correlational, descriptive studies) or controlled trials with inconsistent results.
D. Evidence from expert opinion or multiple case reports.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Decreased occurrence of suicide among elderly individuals who have contact with nurses or other health care providers

Subgroups Most Likely to Benefit:

Elders with warning signs that may signal suicidal ideology and elders who are at risk for attempting suicide

POTENTIAL HARMS

Harm may arise if the protocol is not followed as laid out. It is important that the nurse or other health care provider know her or his professional limits and practice within them. Someone who does not have specialized education in mental health should not attempt to initiate or implement a no-suicide contract. Before using any of the assessment tools or the Psychosocial Assessment Form, the nurse or other health care provider should be completely familiar with the correct way to conduct the assessment, making certain he or she is knowledgeable about all aspects of the assessment. Finally, caution has been given regarding confident reliance on formal assessment tools to determine level of suicide risk. Peer supported clinical judgment is paramount when deciding degree of suicide risk and the appropriate level of intervention.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This evidence-based practice protocol is a general guideline. Patient care continues to require individualization based on patient needs and requests.
- Although psychotherapy is included in the realm of secondary prevention, this protocol is concerned with secondary prevention through the point of appropriate referral.
- Harm may arise if the protocol is not followed as laid out. It is important that the nurse or other health care provider know her or his professional limits and practice within them. Someone who does not have specialized education in mental health should not attempt to initiate or implement a no-suicide contract. Before using any of the assessment tools or the Psychosocial Assessment Form, the nurse or other health care provider should be completely familiar with the correct way to conduct the assessment, making certain he or she is knowledgeable about all aspects of the assessment. Finally, caution has been given regarding confident reliance on formal assessment tools to determine level of suicide risk. Peer supported clinical judgment is paramount when deciding degree of suicide risk and the appropriate level of intervention.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Evaluation of Process and Outcomes

Process Indicators

Process Indicators are those interpersonal and environmental factors that can facilitate the use of a protocol.

One process factor that can be assessed with a sample of nurses or other health care provider is knowledge about elderly suicide. The Elderly Suicide: Secondary Prevention Knowledge Assessment Test (see Appendix C in the original guideline document) should be used before and following the education of staff regarding use of this protocol.

The same sample of nurses or other health care providers for whom the Knowledge Assessment Test is given should also be given the Process Evaluation Monitor (see Appendix D of the original guideline document) approximately one month following his/her education about and use of the protocol. The purpose of this monitor is to determine his/her understanding of the protocol and to assess the support for carrying out the protocol.

Outcome Indicators

Outcome indicators are those patient/client factors expected to change or improve from consistent use of the protocol. The major outcome indicators that should be monitored over time include the following patient behaviors:

- The patient does not attempt suicide.
- The patient seeks help when feeling self-destructive.
- Symptomatic pain, perturbation, and press resulting from the suicide triggering events decreases.

The Elderly Suicide: Secondary Prevention Outcomes Monitor described in Appendix E of the original guideline is to be used for monitoring and evaluating the usefulness of the elderly suicide protocol in improving outcomes of patients at risk of suicide. This outcome monitor should be adapted to an individual organization or unit and outcomes should be added that are believed to be important.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Holkup P. Evidence-based protocol. Elderly suicide: secondary prevention. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2002 Jun. 56 p. [120 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 June

GUIDELINE DEVELOPER(S)

University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core - Academic Institution

SOURCE(S) OF FUNDING

This guideline was developed with the support provided by Grant #P30 NRO3979, National Institute of Nursing Research (NINR), National Institutes of Health (NIH).

GUIDELINE COMMITTEE

University of Iowa Gerontological Nursing Interventions Research Center Research Dissemination Core

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Author(s): Patricia Holkup, PhD(c), RN

Series Editor: Marita G. Titler, PhD, RN, FAAN

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available from the University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core, 4118 Westlawn, Iowa City, IA 52242. For more information, please see the University of Iowa Gerontological Nursing Interventions Research Center Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on October 4, 2002. The information was verified by the guideline developer on October 29, 2002.

COPYRIGHT STATEMENT

Date Modified: 11/15/2004